MEDI-CAL PROGRAM HIGHLIGHTS
CALENDAR YEAR 1995

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THE MEDI-CAL PROGRAM

A BRIEF SUMMARY OF MAJOR EVENTS

INTRODUCTION

The California Medical Assistance Program (Medi-Cal) was established pursuant to Chapter 4, Statutes of 1965, by the Second Extraordinary Session of the California Legislature. The program was enacted to take advantage of federal funds made available by the 1965 Title XIX amendments to the Social Security Act. The stated purpose was to provide "basic and extended health care and related remedial or preventive services to recipients of public assistance and to medically needy aged and other persons, including such related social services as are necessary".

A further intent of the program was that the medical care should be mainstream. Mainstream was defined as comparable to care purchased out of pocket or through private insurance. Prior to Medi-Cal, many public assistance and medically needy persons were forced to rely on charitable institutions, especially county hospitals. These hospitals were generally prohibited by law from accepting paying patients.

The new program also required certain basic services be made available to all beneficiaries. Under the medical programs replaced by Medi-Cal, it was possible to deny medical services to adults in aid to needy children cases, but provide them to other adult beneficiaries.

The new federal law required the State to work towards general improvement in the amount and quality of medical care provided to beneficiaries, improvements in medical social services, and improvements in the organization and delivery of medical care to eligible beneficiaries. The State was also required to work toward extending Medi-Cal coverage to medically indigent persons (noncategorically linked persons 21-64 years old) by July 1, 1977; this was subsequently repealed by the Social Security Amendments of 1972.

ADMINISTRATIVE STRUCTURE

The Office of Health Care Services, Health and welfare Agency, was designated as the agency to coordinate and supervise the activities of the various State departments involved in the Medi-Cal program. Four State departments were directly involved in the Medi-Cal program: Social Welfare, Public Health, Mental Hygiene, and Rehabilitation. The Office was also concerned with policy determination, fiscal and management control, program planning and review, training assistance, and federal program relations.

The sum of $546,000 was appropriated by the Legislation to be used for developmental costs. Planning was centered in the Health and Welfare Agency Administrator's Office, with detail work assigned to the Departments of Mental Hygiene, Public Health, and Social Welfare. Delay resulted at the State level because of late receipt of materials from the Federal Government about Title XIX of the Social Security Act. Few authorized planning positions were filled because of this delay, so substantial work was done by existing staff on an emergency basis. Only about half ($267,500) of the planning money was spent.

The Department of Social Welfare's primary concern was supervision of county operations, especially the determination of eligibility for cash benefits and/or medical care. Public Health was concerned with certification of facilities and certain providers under the program. Mental Hygiene's relation with the Program had to do with eligibility of patients in mental hospitals, while Rehabilitation's concern was rehabilitation of those Medi-Cal beneficiaries who could benefit from training.

In order to meet the March 1, 1966 federal implementation date, the Program contracted with three fiscal intermediaries: California Physician's Services (Blue Shield), the Hospital Service of California (Blue Cross North), and the Hospital Service of Southern California (Blue Cross South). The original contract was to expire December 31, 1966, with provision for a month to month extension. The intention was to extend the contract monthly until a prepayment plan could be implemented, or if prepayment was not feasible, until the State could assume operation of the fiscal intermediary activities. In the Special Addendum to the California State Budget of Fiscal Year 1966-67, it was "anticipated that the fiscal intermediary operation (would) be replaced either by a prepayment system or by State operation no later than July 1, 1976". Neither came to pass, although 227,000 Medi-Cal eligibles were under prepayment by June 1974 and certain fiscal intermediary operations were assumed by groups other than the original Blue Shield-Blue Cross organizations.

The Office of Health Care Services administered the Medi-Cal program until September 14, 1968, when the Department of Health Care Services came into being. The Department was created during a reorganization of the Executive Branch of the State Government. The new Department was undoubtedly an acknowledgement of the significance and magnitude of the Medi-Cal program. The bill paying aspect of the Program continued to be handled through fiscal intermediaries.

In 1973, as part of a plan to centralize administration of programs dealing with health, the Department of Health Care Services was absorbed into the newly established Department of Health. The Medi-Cal program was one of the major divisions of the Department of Health.

Subsequently, in July 1978, the Department of Health was reorganized into five separate departments, one of which is the Department of Health Services. Administration of the Medi-Cal program is one of the Department's major responsibilities.

BENEFITS AND ELIGIBLE PERSONS

The hastily established Medi-Cal program offered one of the most comprehensive programs of medical assistance imaginable to 1.3 million eligible beneficiaries. Previously, public assistance recipients received care under either the Public Assistance Medical Care (PAMC) program or the Medical Assistance for the Aged (MAA). The latter program was for aged persons in need of inpatient extended care. The PAMC program, which was the main medical program, had a number of significant exclusions. Major exclusions were that AFDC adults were not covered except for emergency dental care and outpatient rehabilitation services (services virtually nonexistent). Acute hospital care was only provided for the bind; other beneficiaries had to use the county hospital. Medically needy persons, except certain former MAA beneficiaries, were also excluded from coverage.

Medi-Cal, on the other hand, offered an almost unlimited range of medical services to public assistance recipients, such as inpatient and outpatient hospital services, physician services, laboratory and x-ray, nursing home care, prescription drugs, and ambulance services. The Program covered hearing aids and medical care devices, and services usually not generally available under any insurance scheme, such as chiropractic, podiatry, dentistry, and home health care. The Program also covered organized outpatient mental health programs, birth control devices and drugs, and rehabilitation center services. Some control was placed on the drug program through a drug formulary and prior authorization for certain services and supplies. The controls, however, were nominal.

From the beginning of the Program through September 30, 1971, a major provider of medical services to the poor continued to be county hospitals.

Certain medically needy persons were extended coverage but not on such an elaborate scale. These were persons with income and/or property in excess of the public assistance limitations. These were identified as "Group II eligibles", as opposed to the Group I eligibles who received all the benefits outlined above. Some had a liability amount to pay before Medi-Cal would pay. They received physician and hospital care, nursing home care, laboratory and x-ray services, and prescription drugs. Other outpatient services were available, but only during 90 days following

discharge from inpatient care. The care had to be ordered by a physician, dentist, or podiatrist under conditions relating to the cause of inpatient care. Although California residence was necessary, no period of residence in California was required to receive medical assistance. There was, however, a durational residence requirement for a welfare cash grant.

The full schedule of benefits available to Group I eligibles was extended to all Medi-Cal eligibles effective August 1, 1970. At the same time, more restrictive eligibility standards were put into place for medically needy (Group II) eligibles.

The Medically indigent became eligible for Medi-Cal benefits with the implementation of the Medi-Cal Reform Act of 1971, effective October 1, 1971. The subsequent passage of AB 799 and SB 2012 (Statutes of 1982) transferred responsibility for most medically indigent adults (ages 21-64 years) from the State to the counties effective January 1, 1983. This was in response to a severe fiscal crisis being faced by the State Government.

Medically indigent children (under 21 years old), indigent refugees during their first 18 months of U.S. residence, and indigent adult women with confirmed pregnancies remained eligible for the full scope of Medi-Cal benefits. Medically indigent adults residing in long-term care facilities remained eligible for all Medi-Cal benefits except acute care hospital inpatient services.

THE PROVIDERS

All providers or practitioners who meet the qualifications for licensure or for practicing in the State may provide care or service for Medi-Cal beneficiaries unless suspended from participation. Providers are licensed or certified by various boards or bodies and present evidence to the Department of Health Services in order to be certified and listed on the "master provider list". Out-of-state providers may also service Medi-Cal beneficiaries to the extent the provider is licensed in the other state and the service is a Medi-Cal covered service.

Counties were provided the option of either (1) billing Medi-Cal for services to Medi-Cal eligibles and paying for services to non-Medi-Cal eligibles who were indigent or (2) of increasing their county's contribution to the Health Care Deposit Fund and billing Medi-Cal for care provided to all indigents. This was known as the County Option.

NOTE

This report is for informational purposes only and does not purport to be, or attempt to give, legal interpretation of rules, regulations, and laws pertaining to the Medi-cal program. Questions and comments may be directed to Phyllis Barnhouse, Medical Care Statistics Section (916) 657-2964

HIGHLIGHTS OF 1995 PROGRAM CHANGES

The following discusses the major changes of the Medi-Cal program during Calendar Year 1995.

Mental Health Managed Care Transfer, January 1, 1995

Effective January 1, 1995, the responsibility for administration and payment of inpatient acute psychiatric services has been transferred tot he Short/Doyle Local Mental Health program within Department of Mental Health. Funds for the second half of FY 1994-95 were transferred from the Medi-Cal Local Assistance Item to the Department of Mental Health. General Funds for FY 1995-96 will be incorporated directly into the Department of Mental Health budget, and an interagency agreement with the Medi-Cal program provides the matching federal funds.

Effective April 1, 1995, inpatient and outpatient psychiatric services were transferred for San Mateo County Organized Health System participants, and fee-for-service inpatient acute psychiatric services provided in San Mateo County.

Fifty Cent Reduction in Pharmacy Reimbursement, January 1, 1995

Assembly Bill 2377 (Chapter 147, Statutes of 1994) reduces all prescriptions claims reimbursed through the Medi-Cal outpatient fee-for-service program by fifty cents ($.50) effective January 1, 1995 (14105.336).

Changes to Diagnoses for AID Waiver Program, January 6, 1995

Changes made in the 1995 International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), alter the diagnoses for Human Immunodeficiency Virus (HIV) infection. In the 1994 ICD-9-CM, the diagnoses included all component subdivisions of 042 (Human immunodeficiency virus infection with specified conditions), 043 (Human immunodeficiency virus infection causing other specified conditions), and 044 (Other human immunodeficiency virus infection). The 1995 ICD-9-CM has combined all of the aforementioned codes, making the only valid diagnosis for human immunodeficiency virus (HIV) infection: 042 Human immunodeficiency virus (HIV) disease.

Waivers of Medi-Cal Probate Claims, February 1995

Effective in May 1994, the Medi-Cal program implemented new criteria and procedures to grand hardship waivers of probate claims. These changes were mandated by Welfare and Institutions Code 14009.5 as amended by Senate Bill 177 (Chapter 1201, Statutes of 1989). These regulations were repealed by the Office of Administrative Law

Waivers of Medi-Cal Probate Claims, February 1995 (Continued)

in September 1994, but new emergency regulations were implemented in February 1995. Subsequent to this, regulations were adopted effective April 27, 1995. Due to public comments and revisions proposed by legal staff, the Certificate of Compliance was withdrawn. New regulations were drafted, approved, and adopted, effective March 19, 1996.

Six-Month Exemption for New Drugs, March 1995

OBRA 1993 eliminated the federal requirement that all drugs approved by the Food & Drug Administration (FDA) be a Medicaid benefit, without prior authorization, for six months from the date of FDA approval. State regulations became effective March 1995 eliminating this requirement from the Medi-Cal program.

Dental Root Canal Authorizations, May 1995

New regulation package R-7-95E require prior authorization along with pre- and post-operative x-rays for anterior root canal treatment under the Dental-Cal program. These new regulations became effective on May 1, 1995.

Medi-Cal Targeted Case management (TCM) Program, June 1995

The Medi-Cal program has implemented a claims processing system for Targeted Case Management (TCM) services whereby local governments can claim Federal Financial Participation for the cost of TCM services provided to specific Medi-Cal beneficiaries. Counties and Chartered Cities will provide data, in a prescribed format, which will include the date of service, beneficiary identification number, and appropriate category or service code. The Department of Health Services (DHS) will match the information against the Medi-Cal Eligibility Data System (MEDS) to verify eligibility with the date of service. DHS Accounting will prepare a claims schedule from summary reports, and route the schedule to the State Controller's Office for payment. A yearly payment cap for each county or city will be established. Once the cap is reached, claims will continue to be processed but without payment.

Electronic Funds transfer, July 1995

In early July 1995, the Department of Health Services implemented Electronic Funds Transfer (EFT). This new system allows providers to receive their payments electronically to their banks as opposed to the mail. In order to participate a provider must be in good standing and must sign-up.

State Hospital Releases, July 1995

State Developmental Centers are in the process of being downsized and in some cases closed and are releasing clients into community settings. Clients being placed into community settings receive noninstitutionalized Medi-Cal services on a fee-for-service basis rather than through the Developmental Centers. Regional Centers for the Developmental Disabled assist the Department of Developmental Services and the Department of Health Services in ensuring clients retain access to needed medical services.

Drug Use Review, August 1995

Starting August 1995, the Medi-Cal fee-for-service outpatient drug program began a phase-in implementation of on-line prospective drug use review (DUR). Pharmacists receive on-line messages that indicate one or more possible therapeutic problems at the time of pharmacy claim adjudication.

Change to Aid Code 82, August 1, 1995

Aid Code 82 covers Medically Indigent persons under the age of 21 years who meet the eligibility requirements of Medically Indigent. As of August 1, 1995, Aid Code 82 will also cover persons until age 22 who were in an institution for mental disease before age 21. Persons may be continued in this Aid Code until age 22 if they have filed for a State hearing.

Investigational New AIDS Drugs, August, 1995

Welfare and Institutions Code Section 14137.6 requires the Medi-Cal program to cover, as a benefit, and Treatment Investigational New Drug (TIND) approved by the Food and Drug Administration (FDA) for the treatment of AIDS. The FDA approved a Recombinant Human Growth Hormone (RHGH) for AIDS patients as a means to maintain body weight. There are no existing drugs which treat weight loss; therefore, there are no drugs to be replaced by RHGH treatment.

Vaccine Administration Fee Increase, August 1, 1995

Effective August 1, 1995, the administration fee component for vaccinations was increased from $3.94 to $7.50.

Emergency Drug Authorizations, September 1995

The Department changed the emergency authorization policy of prescription drugs when Medi-Cal pharmacy consultants are unavailable. The new regulations allow the dispensing pharmacist to certify that the condition is and emergency instead of requiring a written certification by the prescribing physician.

New County Health System: Orange County (CalOPTIMA), October 1, 1995

A new County Health Initiative was implemented for Orange County Medi-Cal recipients. The Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) is a Medi-Cal county-wide program administered by the Orange County CalOPTIMA Board of Directors.

The program will have a three-part phase-in process by aid groupings beginning October 1, 1995. CalOPTIMA serves all Medi-Cal-eligible and Medicare/Medi-Cal-eligible recipients who have ID numbers with County Code 30 (Orange County) and one of the following aid codes.

CalOPTIMA Effective Date	
October 1, 1995	(AFDC and AFDC-related aid groupings) 01, 02, 08, 3A, 3C, 3P, 3R, 30, 32, 33, 34, 35, 38, 39, 54, 59, 81, 82, 86
February 1, 1996	10, 14, 16, 18, 20, 24, 26, 28, 36, 6A, 6C, 60, 64, 65, 66, 68
April 1, 1996	03, 04, 13, 17, 23, 27, 37, 4C, 4K, 40, 42, 45, 5K, 63, 67, 83, 87

Transitional Medi-Cal – Married, October 1995

Based on AB836 and AB1371 and a federal waiver, the Department of Health Services and the Department of Social Services have established a program to provide Transitional Child care and Transitional Medi-Cal (TMC) to families discontinued from AFDC due to marriage or the reuniting of separated spouses. This program is being called Wedfare.

Implementation of Aid Codes 0A, 3G, 3H, and 3R – Refugee Cash Assistance and Aid to Families with Dependent Children (AFDC) Recipients Exempt from Grant Cuts, November 1, 1995

The Department of Health Services implemented five new Aid Codes (0A, 3G, 3H, 3P, and 3R) to identify and track Refugee Cash Assistance and Aid to Families with Dependent Children (AFDC) recipients who will be exempt from grant cuts being imposed upon the general AFDC population pursuant to the Assistance Payments Demonstration Project/California Work Pays Demonstration Project. The five new Aid Codes will be assigned to certain recipients previously covered in Aid Codes 01, 30, 32, 33, and 35.

Medicare Crossover Payments, December 1995

State law and regulations require that when billing a claim involves coverage by both Medicare and Medicaid, the maximum reimbursement by Medi-Cal is the Medi-Cal rate established for similar services less the amount Medicare pays. The Department of Health Services has not been paying for Medicare deductibles and co-insurances for hospital inpatient care for services rendered on and after May 1, 1994.

The U.S. District Court for the Central District of California has ruled in the case of Beverly v. Belshé that the State law does not apply to any person that can be considered a Qualified Medicare Beneficiary (QMB). The Department of Health Services has determined that all SSI/SSP eligibles and all Medi-Cal Only eligibles with and Aid Code or Subcode of 80 must be considered QMBs effective December 11, 1995.

Managed Care Expansion – Two-Plan Model

Implementation of the two-plan model began January 1996, when the first of twelve counties (Alameda) implemented their county initiative. San Joaquin implemented their county Initiative February 1996. The bulk of the remaining 10 counties (Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, Santa Clara, Stanislaus, and Tulare) is expected to implement in the Budget Year. The monthly enrollees represent the shift from Fee-For-Service to Managed Care for Public Assistance – Families, Medically Needy – Families, and Medically Indigent Children only.

Medi-Cal funding for some CCS Medical Therapy Units

California Children Services (CCS) Medical Therapy Units will begin billing direct to Medi-Cal for physical and occupational therapy services provided to Medi-Cal eligible children. These services will continue to be provided in CCS Medical Therapy Units, however, those units which are certified as Medi-Cal providers may bill for these services to the Medi-Cal program. Billing of Medi-Cal was implemented July 1, 1994 with retroactive billing to September 1, 1993.